

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036226

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318 XC-

1003 SL-29345

8819

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED SEP 17 1962

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 2 DAYS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR VAH ST LOUIS MO. INSTITUTION		d. STREET ADDRESS (If outside, give location) 5205 PIERCE AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM F. HARMON		4. DATE OF DEATH Month Day Year SEPT. 11 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-23-92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURNITURE FINISHER		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME ROBERT HARMON		11b. MOTHER'S MAIDEN NAME WILLIAMS	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) YES 7-12-18 1-17-19		12b. SOCIAL SECURITY NO.	
13a. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary arteriosclerosis DUE TO (c) 420.1		13b. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Emphysema		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. attended the deceased from 9-9-62 to 9-11-62 and last saw him alive on 9-11-62 Death occurred at 8:20 AM on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) John R. Hogan M.D.	
22b. ADDRESS VAH, ST. LOUIS, MISSOURI		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE SEPT. 14 1962	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO
24. FUNERAL DIRECTOR Thomas Kuttie 2906 Gravier		25. DATE RECD. BY LOCAL REG. SEP 12 1962	
26. REGISTRAR'S SIGNATURE Earl Smith M.D.			

USE BLACK INK

OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4861

P. O. Address St. Louis 19, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.